BUREAU OF INSURANCE
BASIS STATEMENT AND SUMMARY OF COMMENTS
ADOPTION OF 02-031 C.M.R. CHAPTER 856
COMBINATION OF THE INDIVIDUAL AND SMALL BUSINESS
HEALTH INSURANCE RISK POOLS

Superintendent of Insurance Eric Cioppa hereby adopts Chapter 856, Combination of the Individual and Small Business Health Insurance Risk Pools. This rule implements provisions of the Insurance Code added by P.L. 2019, ch. 653 (L.D. 2007), An Act To Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine, as amended by P.L. 2021, ch. 361 (L.D. 1725), An Act To Clarify the Deferral of the Pooled Market and Link Small Employer Clear Choice to Pooling in the Made for Maine Health Coverage Act.

Pursuant to a Notice of Rulemaking issued on September 10, 2021, Superintendent Cioppa held a public hearing on October 12, 2021, and the public comment period was open until October 25, 2021 at 4:30 p.m.

The rule was proposed to establish the necessary conditions and procedures for implementation of the pooled individual and small group health insurance market, and the extension of Maine Guaranteed Access Reinsurance Association (MGARA) coverage to small group health insurance as provided in 24-A M.R.S. § 3958(1)(A-1). It also authorizes MGARA to implement a retroactive reinsurance program for individual health insurance in 2022 and, if applicable, in any subsequent year in which the pooled market has not been implemented. The rule is hereby adopted with the revisions set forth below in the Bureau's responses to comments.

A. The following persons testified at the hearing and also submitted written comments on or before October 25, 2021:

Christopher E. Howard, Esq.
Pierce Atwood LLP
on behalf of MGARA

Katherine D. Pelletreau
Executive Director
Maine Association of Health Plans (MeAHP)

Kevin Lewis
President and CEO
Community Health Options (CHO)

Kristine M. Ossenfort, Esq.
Senior Government Relations Director
Anthem Blue Cross Blue Shield of Maine

B. The following additional persons submitted written comments on or before October 25, 2021:

Joel Allumbaugh
President
The Allumbaugh Agency

Dan Colacino
Vice President
Maine Association of Health Underwriters (MaineAHU)

Peter M. Gore
Executive Vice President
Maine State Chamber of Commerce (MSCC)

Unsigned letter submitted by
Harvard Pilgrim Health Care (HPHC)

Kate Ende
Policy Director
Consumers for Affordable Health Care (CAHC)

C. Summary of comments and Bureau of Insurance responses:

1. General Comments

Comment: MGARA believes that "Proposed Rule 856 sets out a clear and workable process," and CAHC commented that it "could increase market stability and help provide much needed relief" to small business owners and employees who are struggling to afford coverage.
Comment: HPHC said they "understand and support the policy goals of Proposed Rule 856," but "continue to believe the first step forward is to put the brakes on merging the markets and allow for these changed market conditions to level off and re-stabilize before proceeding with further changes of unknown consequence." They are concerned about the prospect that the pooled market might accelerate the flight of lower-risk employers to experience-rated level-funded plans. CHO shared similar concerns. Anthem emphasizes that "Maine cannot afford to take any actions that would have the effect of increasing individual market rates."
Comment: Several commenters, while aware that legislation cannot be undone by rulemaking, reiterated their opposition to the provisions of L.D. 1725 that amended the language of the comparison test in 24-A M.R.S. § 2792(5), as incorporated within the proposed rule at Subsection 4(2), which is discussed in more detail in the summary of the section-specific comments below. MeAHP was "disappointed to see the Administration formally change the base year calculation via legislation." Similarly, CHO is "not in favor of disrupting a program that has successfully stabilized premiums in the individual market," and they "remain concerned that without the guardrails established by the original statute, the proposed merger of the individual and small group markets does not serve the best interests of both individual

policyholders and small employers in Maine." MaineAHU "did not support the pooling of the Individual and Small Group markets for rating purposes when it was proposed under LD 2007," but said they "had confidence that the process to determine if the merger was to go forward would show that there were no, or at the very least, minimal savings to the small group market." However, they are now concerned that as a result of the legislation, they no longer "feel the analysis will produce a result which forecasts realistic savings."
Comment: MSCC noted that it had previously "expressed concerns with the level of 'unknown' that exists with the merger of the two markets. We also agreed with you that something needed to be done to address the issues of continually rising costs and shrinking size, particularly within the small group market. While some of our concerns have not abated," they "recognize and appreciate the work both Governor Mills and you have put into trying to creatively address rising health insurance costs for small businesses," and emphasize that communication and the provision of timely and accurate information as to the progress and outcomes of the merger will be crucial.

Bureau Response: We appreciate the range of thoughtful comments, from a variety of perspectives, highlighting both the challenges and the opportunities that arise from the pooled market process. With regard to the MaineAHU comment, it should be noted that the language related to expected savings for small employers, their stated area of concern, was not changed by the recent legislation. We must operate within the policy framework established by the Legislature, and we are very cognizant of our duty to carefully weigh the likely costs and benefits, and ensure that the pooled market will only be implemented if MGARA will provide enough savings to small employers to offset any adverse impact on the small group market from pooling risk with the individual market. The comments have made many constructive suggestions about the Bureau's implementation of the pooled market legislation, as discussed below, and we have addressed these in the rule within the constraints set by the enabling statute.

Comment: CHO is skeptical about "squeezing small group plan designs into the Clear Choice architecture of the individual market." HPHC offered some specific suggestions for new Clear Choice Plan designs to address the needs of small employers.

Bureau Response: We recognize the importance of ensuring that Clear Choice designs will meet the needs of employers once the pooled market is implemented, and we appreciate the suggestions that have been offered to help us carry out that responsibility. Although they are outside the scope of this rulemaking proceeding, we are actively taking these suggestions into account as we continue the development of future Clear Choice plan designs.

Comment: HPHC proposes tightening the regulation of stop-loss products "to reflect true self-insurance" rather than what they characterize as the "pseudo self-insurance" of the level-funded market, and expanding the small group market to increase the maximum number of employees from fifty to some higher number to be determined.

Bureau Response: Both of these suggestions are beyond the scope of this rule, and would require legislative action. However, they are responsive to the general request, as codified in this rule,-

for suggested initiatives that might improve market stability and affordability. They will be given thorough consideration in that context.

2. Comments on Specific Provisions:

Section 2, applicability and scope

Comment: Anthem comments that the language making the rule applicable to plans "providing coverage [on or] after January 1, 2023" should be revised to refer to plans "issued or renewed in a pooled market on or after January 1, 2023," to address the possibility that the pooled market is not implemented in 2023.

Bureau Response: Proposed Section 2 was worded broadly because technically, the rule has an effect on individual and small group health plans even in scenarios where the effect is to preserve the *status quo.* However, we agree with Anthem that this approach was confusing, and therefore have revised Section 2 to refer specifically to "pooled market health plans." This change also allows the structure of Section 2 to be simplified by removing language limiting the scope to individual health plans covering Maine residents. That limitation is no longer necessary because it is part of the definition of "pooled market health plan." As discussed below, conforming revisions have also been made to Subsection 3(5) and Subparagraph 5(2) (C)(1). As revised, Section 2 now reads as follows:

> This rule shall apply to all individual health plans, as defined in 24-A M.R.S. §2736 C(1)(C), ~~covering Maine residents,~~ and to all small group health plans, as defined in 24-A M.R.S. §2808-B(1)(G), ~~providing coverage~~ issued or renewed as pooled market health plans on or after January 1, 2023. Section 6 applies to the operations of the Maine Guaranteed Access Reinsurance Association on and after January 1, 2022.

Subsection 3(1), definition of "carrier"

Comment: Anthem asks us to change the definition of "carrier" to exclude multiple-employer welfare arrangements (MEWAs) and the state employee health plan.

Bureau Response: We agree that the rule does not apply to MEWAs, nor to the state employee health plan. However, the way to specify that a certain type of health coverage is outside the scope of the rule is through the Scope Clause, not by redefining terms of general applicability to declare that the carrier providing that coverage is something other than a carrier. Section 2, which establishes the scope of the rule, makes clear that the rule does not apply to the types of coverage provided by MEWAs or by the state employee health plan. Furthermore, if those carriers did provide small group health plans within the meaning of 24-A M.R.S. § 2808-B, then they would be subject to the rule.

Subsection 3(5), definition of "pooled market health plan"

Comment: Anthem questioned why "a multiple-employer plan that has been approved as a separate rating pool under 24-A M.R.S. §2808-B(2)(E)" is excluded from the pooled market when such plans are included in the Clear Choice program under Rule 851.

Bureau Response: There is no inconsistency. These plans, sometimes referred to as "association health plans" (AHPs) are also outside the scope of Rule 851 and its enabling statute 24-A M.R.S. § 2793. The pooled market will combine each participating carrier's statewide individual and small group rating pools, but the defining characteristic of AHPs is that they have been excluded from the carrier's statewide small group rating pool. The coverage issued through an approved AHP does not need to be made available to small employers outside the sponsoring association or trust, and is expressly designated as "large group" coverage under 24-A M.R.S. § 2808-B(2)(E)(3), except for purposes of community rating within the AHP.

Comment: In its comment to Section 2, Anthem requested that the trigger for applicability be changed from "providing coverage" to "issued or renewed" on or after the implementation date.

Bureau Response: The same concerns also apply to the definition of "pooled market health plan," and here they actually affect the substance of the rule, not merely its clarity. 24-A M.R.S. § 2792(1) specifically ties the implementation of the pooled market to the plan's "effective date of coverage." Therefore, Subsection 3(5) has been revised as follows:

> "Pooled market health plan" means any individual or small group health plan, as defined in 24-A M.R.S. §§ 2736 C(1)(C) and 2808-B(1)(G), ~~providing coverage~~ issued or renewed in this State during or after the implementation year, other than a multiple-employer plan that has been approved as a separate rating pool under 24 A M.R.S. §2808-B(2)(E).

Subsection 3(7), definition of "retrospective reinsurance program"

Comment: As proposed, "retrospective reinsurance program" is defined as covering "all eligible policies ... without regard for an insured individual's health condition and without requiring any advance designation as a high-risk policy." Anthem requests changing "advance designation as a high-risk policy" to "advance designation for reinsurance," noting that some coverage under the current prospective system is provided through mandatory cession based on a list of designated health conditions.

Bureau Response: Although the mandatory cedes are mandatory precisely because MGARA has determined that the listed conditions are high-risk, we agree that the "high-risk" language is not necessary, and Anthem's suggested revision tracks the wording of the caption to 24-A M.R.S. § 3959. Therefore, the requested change has been made:

"Retrospective reinsurance program" means a reinsurance program under which all eligible policies are covered by the Association, without regard for an insured individual's health condition and without requiring any advance designation ~~as a high-risk policy~~ for reinsurance.

Paragraph 4(1)(A), Superintendent's actuarial analysis

Comment: Paragraph 4(1)(A) directs MGARA to provide an estimate of the impact of pooling on "reinsurance parameters ... including ... any reinsurance caps and ceding premiums." Anthem wants to eliminate the reference to "ceded *[sic]* premiums." According to Anthem, one distinguishing feature of a retrospective program is that "reinsurance will apply to members who reach the attachment points and there will no longer be a need for policies to be ceded."

Bureau Response: It is not accurate to say that under a retrospective program "there will no longer be a need for policies to be ceded." The switch to a retrospective program will have the opposite effect, and all policies will be ceded to MGARA, within the designated layer of coverage. MGARA is permitted but not required to continue to charge a ceding premium for the coverage it provides. That flexibility was requested by MGARA at the time the legislation was being developed. Although MGARA has not chosen at this time to include a premium within its reinsurance parameters, the reference to "any" ceding premiums, here and in Paragraph 6(2)(B), is necessary to address the contingency that MGARA might make a different choice in the future.

Paragraph 4(1)(B), solicitation of public input on impact of pooling

Comment: Anthem "would suggest that the rule should specifically require the Superintendent to hold a public hearing on the expected impact of [the] pooled market."

Bureau Response: The rule establishes a transparent, inclusive, and interactive process for receiving and reviewing all relevant information before arriving at our conclusions on the expected impact of pooling or not pooling the market. Paragraphs 4(1)(B) and (C), as proposed, already require the solicitation of public input and "at least one forum where the public may provide comments and ask questions." It is not clear what would be gained by calling these forums "hearings," unless Anthem is requesting a requirement for a formal adjudicatory proceeding. We do not believe the constraints of the Administrative Procedure Act hearing procedures are appropriate for this process, especially in light of the need, which Anthem and others have emphasized, for prompt and expeditious action.

Paragraph 4(1)(B), additional proposals to improve market stability and affordability

Comment: This paragraph directs the Superintendent to solicit public input on topics that include "suggestions for additional or alternate initiatives to improve the stability and affordability of the

small group market." CAHC suggests that we expand the scope to include the individual market as well as the small group market.

Bureau Response: This provision facilitates the implementation of 24-A M.R.S. § 2792(5), which requires the Superintendent to "conduct an analysis of alternative proposals to improve the stability and affordability of the small group market" in the event that the pooled market is not implemented and MGARA continues to be unavailable to reduce small group claim costs. We agree that it is also important to have free-ranging discussions of health reform in general, but not to mandate such discussions at a time and place where they would dilute the focus of a specific inquiry we need to conduct.

Subsection 4(2), review of expected savings compared to baseline scenario

Comment: This subsection requires the Superintendent to compare projected pooled market premiums "to a baseline with no pooled market and no subsidized reinsurance program." Anthem acknowledges that this requirement is necessary, because it is mandated by 24-A M.R.S. § 2792(5), as amended by L.D. 1725, but states that "the Superintendent still has the discretion to compare individual markets rates as they are today with MGARA reinsuring the individual market to individual rates in a pooled market scenario and we would urge him to do so." MeAHP likewise requests "a full analysis that includes the use of a base year with reinsurance. We also suggest that analyses be as current as possible, especially given the unusual claims experience of COVID-times." CHO joins in the request "that the decision to proceed should weigh the full effects of such a merger, including the possible negative impacts on the individual market."
Comment: CAHC asks for the impact on individual market premiums to "be measured **using net premium costs for individuals (after any applicable premium subsidies)**, rather than the base premium rates, which do not reflect actual premium costs for most Mainers enrolled in individual market coverage." *(Emphasis in original)*

Bureau Response: We do not agree that the statutory phrase "average individual premium rates," as used in 24-A M.R.S. § 2792(5), was intended to mean premiums net of applicable subsidies. Most Marketplace policies are subsidized, and under the ACA, the net premium impact by design is zero for any consumer who is eligible for subsidies and buys the second-cheapest Silver plan on the Marketplace. The actual impact on individual consumers will depend on their separate buying decisions, and cannot be objectively quantified with any substantial degree of precision. The Superintendent does not have the discretion under the law to use the net impact after subsidies on individual consumers as a reason for changing the determination whether to go forward with a Section 1332 waiver application, which is the second step in this process. For the same reason, the net impact on aggregate individual market premiums after MGARA reinsurance is not a factor that can change this statutory determination. However, we agree that the issues raised by these comments could be relevant factors in the access and affordability analysis for any innovation waiver application. These are topics that interested persons would be able to raise in the course of the process as already proposed, so no revisions to the rule are necessary to address these concerns.

Paragraph 4(2)(A), comparison to baseline scenario

Comment: This paragraph provides that "the Superintendent shall proceed with the implementation process," including but not limited to a Section 1332 innovation waiver application, if the pooled market is projected to generate savings for both individuals and small employers. Anthem proposes changing "shall" to "may," to give the Superintendent the discretion to disregard minuscule savings projections.

Bureau Response: Changing "shall" to "may" would be inconsistent with 24-A M.R.S. § 2792(1), which requires that individual and small group health plans offered in this State with effective dates of coverage on or after January 1, 2023 "must be offered through a pooled market" if the conditions set forth in 24-A M.R.S. § 2792(5) are met. However, this does not obligate the Superintendent to act improvidently if the savings are *de minimis* or merely speculative. Because there is an inherent margin of uncertainty in all actuarial projections, any factors that cast substantial doubt on the materiality of any projected savings will also call into question the likelihood that savings will actually be realized.

Comment: CAHC raised the opposite scenario: what if there are significant savings for one class of policyholders and no harm to the other class? Can the pooled market still go forward? CAHC points out that the proposed language of Paragraph 4(2)(A), which requires expected average premium to be lower for each market sector, is inconsistent with 24-A M.R.S. § 2792(5), which says "the same or lower." CAHC notes further that other provisions in Subsections 4(2) and 4(4) are also affected.

Bureau Response: CAHC is correct. They did not specifically identify the other provisions that were affected, but they were Paragraphs 4(2)(B), 4(4)(B), and 4(4)(C). Given the practical impossibility of any determination that the impact is precisely zero, this does not open the door for implementation to go forward with no meaningful expectation that the market will benefit. The relevant provisions have been revised as follows:

4(2)A. If the Superintendent finds that the average premium for individuals in the pooled market scenario is expected to be the same or lower than the average premium for the individual market in the baseline scenario, and that the average premium for small employers in the pooled market scenario is expected to be the same or lower than the average premium for the small group market in the baseline scenario, the Superintendent shall proceed with the implementation process as provided in subsections 3 and 4.

B. If the Superintendent does not find, in accordance with paragraph A, that the pooled market scenario is expected to ~~yield~~ avoid adverse premium ~~savings~~ impacts for both individuals and small employers in the provisional implementation year, the Superintendent shall defer implementation as provided in subsection 6.

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4(4)B. The Superintendent finds that the proposed terms and conditions of an approved innovation waiver amendment would not be expected to ~~yield~~ avoid adverse premium ~~savings~~ impacts for both individuals and small employers; or

C. The Superintendent finds that in light of new and persuasive information about recent or expected market experience, it is no longer expected that the implementation of the proposed innovation waiver amendment would ~~yield~~ avoid adverse premium ~~savings~~ impacts for both individuals and small employers.

Subsection 4(3), federal innovation waiver application
Paragraph 4(3)(C), other potential state-federal partnership opportunities

Comment: MGARA asked us "to include consultation with MGARA regarding the application for an innovation waiver amendment under Section 4, subsection (3) of the Proposed Rule. Although the application is submitted by the State, MGARA will be the organization charged with implementing the reinsurance program described in the application and therefore feels it would be beneficial to be included in a collaborative process for preparing and submitting the application."
Comment: CAHC strongly encourages adding a process for public input on any additional proposals that might be submitted under Paragraphs 4(3)(B) or (C), noting that public input might not have been solicited in any previous forums or hearings held in connection with the initial pooled market impact analysis or preliminary innovation waiver application.

Bureau Response: We agree with these suggestions. We have also made other clarifying revisions to Subsection 4(3) which now reads as follows:

3. *State-Federal Partnership ~~Application~~ Applications*. The Superintendent shall initiate planning for an innovation waiver amendment as part of the review process conducted under subsection 1.

A. The Superintendent shall ensure timely compliance with all applicable application requirements.

B. ~~The~~ In addition to the pooled market and pooled reinsurance program, an innovation waiver application may also include any other provisions that would improve the stability and affordability of the small group market or would otherwise benefit the operation of Maine's health insurance market.

C. ~~The~~ Whether or not the pooled market is implemented, the Superintendent shall consider whether there are any other opportunities for state-federal partnerships, as defined in 24-A M.R.S. §2781, or private funding, that would provide additional resources for the Association or otherwise

benefit the operation of Maine's health insurance market, and initiate or coordinate applications as the Superintendent considers appropriate.

D. The Superintendent shall ensure that the Association and all other interested parties have a meaningful opportunity for input in developing any application submitted under Paragraphs A through C.

Subsection 4(4), final decision on implementation

Comment: Anthem requests "that the rule include dates certain by which actions must be taken in order for a merger to move forward." CHO, HPHC, and MeAHP all raised similar concerns, noting the need for certainty during the rate filing process and the avoidance of unnecessary administrative costs. The comments said a decision by December is necessary so that products can "be finalized by March," in Anthem's words, or "February (March at the latest)," in MeAHP's words.

Bureau Response: We understand and share these concerns, and have been striving to meet the same schedule. Codifying a specific deadline, however, could have unintended consequences and deprive us of the flexibility to respond to unforeseen circumstances.

Comment: Anthem also requests amending Subsection 4(4) to "clarify that the determination to implement a pooled market is a final agency action subject to appeal."

Bureau Response: As noted earlier, our process must be transparent and inclusive, but it must also be efficient. It would frustrate the needs of all parties, as noted above in Anthem's own comments and those of other carriers, for the rule to require convening a formal adjudicatory proceeding. Whether the Superintendent's decision might otherwise constitute "final agency action" is a matter for the courts to decide if and when an affected party might seek to appeal the decision. Therefore, we are not making the change Anthem has requested. However, while reviewing this comment, we realized that the title of this subsection needs to be changed to read:

4. *Final Decision Whether to Implement Pooled Market.*

Paragraph 5(1)(A), coverage available only during annual and special enrollment periods

Comment: Anthem commented: "It is not clear what annual open and special enrollment periods would be available to small employers who fail to meet minimum participation requirements." Anthem suggests keeping the current window which runs from November 15 to December 15.

Bureau Response: The Bureau of Insurance is not the agency that establishes the enrollment periods. November 15 to December 15 for small employers that do not meet the generally applicable participation requirements is already established by federal law, at 45 CFR § 147.104(b)(1)(i)(B), and we are not aware of any proposal to change it.

Subsection 5(1)(A), plans available to all individuals and small employers

Comment: MeAHP expressed concern that guaranteed issue across the pooled market might not be compatible with "right to shop laws that apply only to certain small group plans."

Bureau Response: We understand this comment to be a reference to the "comparable health services" pilot program under 24-A M.R.S. § 4318-A. This is currently scheduled to sunset in 2024, but in 2023, carriers must make these incentives available "at a minimum, for all small group health plans ... compatible with a health savings account authorized under federal law." Because these incentives relate to cost sharing, we believe that this issue is best discussed during the pending stakeholder process for the 2023 Clear Choice designs.

Paragraph 5(1)(C), carrier discretion whether to offer plans on Marketplace

Comment: As proposed, Paragraph 5(1)(C) includes language clarifying that "A carrier may vary its marketing strategies and distribution channels, including the decision whether to offer a plan to individuals or to small employers on the Maine Health Insurance Marketplace." Because the federal SHOP program has been restructured so that Marketplaces no longer offer small group coverage, Anthem proposes deleting the reference to small employers.

Bureau Response: We agree. The limiting language "to individuals" is also unnecessary, and this paragraph has been simplified to read:

> This subsection does not require carriers to market all pooled market health plans in the same manner to all customers. A carrier may vary its marketing strategies and distribution channels, including the decision whether to offer a plan ~~to individuals or to small employers~~ on the Maine Health Insurance Marketplace established pursuant to 22 M.R.S. §5403, between one plan and another, between one service area and another, or between individuals and small employers, as long as the carrier does not discriminate on the basis of actual or perceived health risk or other prohibited classifications.

NEW Paragraph 5(1)(E), carrier discretion whether to offer plans on Marketplace

Comment: MeAHP's comments on Subsection 5(3), as discussed more fully in that section of this Basis Statement, have highlighted the need to clarify that it is impossible to issue the identical coverage documents to individuals and small employers, and certain contract terms must be permitted to vary between the version of a plan offered to individuals and the version offered to small employers, without deeming them to be "different plans" in violation of the marketwide guaranteed issue requirement.

Bureau Response: A new Paragraph E has been added to Subsection 5(1). It reads as follows:

> E, This section does not prohibit differences in the administrative provisions of the policy forms issued to individuals and the coverage documents for the same plan issued to small employers and plan participants, if the variations in contract terms are reasonably related to the differences in the mode of coverage, and do not affect the plan benefits or premium rates except to the extent expressly permitted by this rule or required by controlling law.

Subsection 5(2), unified rating process

Comment: HPHC asked how tobacco rating factors will be implemented in a pooled market when, according to HPHC, "the individual market allows for tobacco use rating while the small group market does not."

Bureau Response: Under the Maine Insurance Code, the tobacco rating provisions for the individual and small group markets are identical, under 24-A M.R.S. §§ 2736-C(2)(D)(8) and 2808-B(2)(D)(9). The differences HPHC mentions arise from the federal requirements under the ACA, which are more complex. Section 2701 of the Public Health Service Act, on its face, is less restrictive than state law, allowing tobacco surcharges of up to 50% in both the individual and small group markets as compared to a maximum of 25% under state law for plans issued or renewed in 2023. However, a separate federal regulation implementing the nondiscrimination requirements prohibits traditional tobacco rating in both the small and large group markets. 45 CFR § 146.121(c). But that prohibition is subject to an exception that permits both carriers and employers to impose tobacco use surcharges on plan participants, subject to certain conditions, as long as participants who use tobacco can avoid the surcharge for each plan year by participating in a tobacco cessation wellness program. *See* 45 CFR §§ 146.121(c)(2)(iii) & (f)(4)(vi) Example 6. This is substantially similar to Maine's prohibition – applicable to both individual and small group coverage – against applying tobacco use surcharges when a covered person is participating in an FDA-approved evidence-based tobacco cessation strategy. If our understanding of the federal requirements is accurate, Maine's tobacco rating requirements are at least as restrictive for both individual and small group coverage, which would eliminate the discrepancies that would otherwise be permitted under the ACA. Even if a conflict exists, it could be addressed through the Section 1332 waiver process, and any remaining conflict would be subject to federal preemption, consistent with Subsection 5(3) of the rule. It should also be noted that the entire issue will be moot after 2023, when the phaseout of tobacco rating established by P.L. 2021, ch. 344 (L.D. 1150) is complete, and tobacco surcharges will be prohibited for both individuals and small employers on and after January 1, 2024.

Paragraph 5(2)(A), composite rating permitted

Comment: This paragraph permits the continued use of composite rating for small group coverage. Anthem commented "that Individual and Small Group rates will not directly

correspond when composite rating is used for Small Group plans," and that there is a conflict between the provisions of Bulletin 404 that prohibit any changes in a composite rate during the plan year and the requirement in Paragraph 5(2)(C) to adjust all rates on a calendar-year basis.

Bureau Response: There is no conflict between composite rating and the general requirement for parity between individual and small group rates, because composite rating was expressly proposed as a permitted exception. However, Anthem is correct that if the calendar-year rating requirement remains in force, Bulletin 404 will need to be changed. The simplest methodology appears to be to apply the same percentage adjustment to a composite rate on January 1 that would have been made to the same plan's premium if it were issued on an individually rated basis and there were no changes in the employee census after the effective date of coverage. However, the Superintendent would consider alternative suggestions if this is still an issue when it is necessary to make that decision.

Paragraph 5(2)(C), calendar-year rating
Subparagraph 5(2)(C)(1), mid-year rate adjustment for non-calendar-year small group plans

Comment: These provisions received the most comments. As proposed, they would require all pooled market health plans to be rated on a calendar year basis, providing that: "Carriers may only change their rating schedules once a year, with a January 1 effective date." Carriers could continue offering small group plans on a non-calendar-year basis, and accruing deductibles and out-of-pocket maxima on a plan-year basis, but the rates for non-calendar-year plans must be adjusted on January 1 in a manner consistent with the applicable rate adjustment for a new plan issued on a calendar year basis, MGARA, CHO, Anthem, the Allumbaugh Agency, MaineAHU, MSCC, HPHC, and CAHC all opposed these provisions and urged retention of the current system. As MGARA described the proposal, it "appears to require the consolidation of small group renewals into a single January 1 renewal cycle." Anthem, more accurately, acknowledged that the Rule does allow non-calendar-year rating, but expressed concern that the calendar-year rating provision "may have the unintended consequence of moving people to 1/1 renewals," or out of the traditional insurance market entirely. Several comments expressed concerns that the prospect of a midyear rate increase makes both shopping and budgeting more difficult for employers (except when the employer's anniversary date is late enough in the year that carriers' rates for the following year have been finalized, with the ironic result that "self-insurance" can provide more predictable costs for small employers with risk profiles that can give them access to the level-funded market. Similarly, the inability to adjust rates on a quarterly basis creates more uncertainty for carriers, and brokers were also concerned that driving more employers into calendar-year plans would disrupt their operations and create inefficiencies by concentrating their workload at a single point in the year. Uniform January 1 renewals would also be inefficient for employers whose natural operating year is different from a calendar year. HPHC observed that other alternatives are available, because Massachusetts successfully operates a merged market with quarterly small group rate adjustments. Anthem added that any inconsistencies with the ACA could be addressed, subject to federal approval, through the ACA Section 1332 waiver process.

Bureau Response: While the concerns expressed are valid, the calendar-year rating requirement is not new. It did not originate with this rulemaking proposal, but rather is mandated by the underlying requirements of the Insurance Code. The relevant language in 24-A M.R.S. § 2792(2) is unchanged from the time it was initially proposed as part of L.D. 2007 in January 2020. It reads as follows:

> For health plans that are issued on other than a calendar year basis, rates applicable on and after January 1st of any plan year must be the approved rates for the most similar plan offered during the new calendar year, adjusted by a factor, approved by the superintendent as part of the rating plan, that appropriately accounts for any differences in plan design.

This gives non-calendar-year employers parity in premium rating with calendar-year employers and individuals. Each policyholder with the same plan pays precisely the same monthly rate from January through December of each calendar year, even when those 12 months are spread across two different plan years. The process was designed to be cost-neutral and revenue-neutral for both carriers and employers, relative to the current system of plan-year small group rating with quarterly adjustments, and we will implement it to carry out that intent if it remains in effect. It was also designed to comply with federal regulations prohibiting quarterly rate adjustments in a merged market. However, as stakeholders have focused on the implementation of this provision, they have identified unintended consequences that give rise to significant problems. There is a strong consensus that Maine should, if possible, retain the current system, where an enrollee's premium cannot change until the policy's next renewal date, but carriers can adjust their rating schedules each quarter for small group policies issued or renewed during that quarter. The Massachusetts experience illustrates that the federal regulation does not prohibit quarterly rate adjustments. Instead, the practical effect is that technically, the Massachusetts market is not classified as a "merged market." Because Maine's calendar-year rating mandate is statutory, we cannot change it through rulemaking. However, we have revised Subsection 5(2) so that the rule will not interfere or conflict with any new framework that might be established to replace or modify the current framework. The rule continues to provide for a single set of unified rates effective January 1 of each year, but is silent as to possible midyear adjustments. As revised, Subsection 5(2) reads as follows:

2. *Unified Rating Process.* Proposed rates for all pooled market health plans shall be filed and reviewed annually in accordance with 24-A M.R.S. §§ 2736 through 2736-C, which shall supersede any provisions of the Insurance Code that would otherwise establish different requirements or procedures for small group health plans. ~~Rates shall not vary on the basis of whether the plan is issued to an individual or a small employer.~~

   A. This subsection does not prohibit composite rating of small group health plans, to the extent permitted by federal law, in accordance with procedures published by the Superintendent.

   B. Catastrophic plans shall be adjusted for the expected impact of the special eligibility categories for these plans. Carriers may not recover this

adjustment elsewhere in the rating process, because such an adjustment would remove the catastrophic plan experience from the single risk pool,

~~C. Beginning with the implementation year, all pooled market health plans shall be rated on a calendar year basis. Carriers may only change their rating schedules once a year, with a January 1 effective date.~~

~~(1) Rates for each non-calendar-year small group plan shall be adjusted on January 1 of each year, beginning with the implementation year, to conform to the rating schedule for the most similar plan offered by the carrier during the new calendar year, applying factors approved by the Superintendent to account for any benefit and cost-sharing differentials between plans.~~

~~(2) This paragraph does not prohibit non-calendar year plans from accruing their deductibles and out-of-pocket maxima on a plan year basis.~~

Subparagraph 5(2)(C)(1), implementation of calendar-year rating

Comment: As proposed, this subparagraph would have made calendar-year rating applicable to "legacy" small group plans in force on the implementation date by requiring a rate adjustment on January 1 of the implementation year. As Anthem had commented in response to Proposed Section 2, the rule should only apply to plans issued or renewed as pooled market health plans.

Bureau Response: We agree that even if the calendar-year rating requirement is retained, it should not apply to plans that were issued before the implementation date and designed and rated for a stand-alone small group market. As noted earlier in the context of Subsection 3(5), the controlling provision of the Insurance Code expressly links the pooled market to the effective date of coverage. As the introduction to Paragraph 5(2)(C) already specifies, calendar-year rating is only required "for all pooled market health plans." Therefore, the phrase "beginning with the implementation year" should not have been included in Subparagraph 5(2)(C)(1). However, that issue is moot now that Paragraph 5(2)(C) has been deleted in its entirety.

Subsection 5(3), risk adjustment

Comment: Subsection 5(3) requires the Superintendent's pooled market implementation plan to address compliance with the ACA, with prompt notice to applicable federal officials, and specifically includes risk adjustment as one of the issues to be addressed. Anthem asks how risk adjustment will operate, especially during the implementation year when the small group market includes both pooled market plans and the tail months of legacy plans. MeAHP adds that there are at least two methodologies that could be used on an ongoing basis, and might be more. Their preferred approach "would be for risk adjustment to continue to be calculated within each market and netted out," because conducting a single risk adjustment process for the pooled market from

the ground up "would seem to necessitate establishing a crosswalk with CMS and the management of each carrier's respective EDGE servers." They also warn that "a Maine-specific variation could add complexity and costs to an already complex system,"

Bureau Response: We agree that the issues are both important and complex, and it would be premature to codify the details of the risk adjustment program in this rule. We appreciate this feedback, and any other input that knowledgeable stakeholders can provide during the process for developing any pooled market implementation plan and innovation waiver application.

Subsection 5(3), ACA compliance generally

Comment: MeAHP also expresses concerns about how "Rescission and grace period standards in the individual market" will affect the small group market, and note that the compatibility issues they have raised here and in other comments are not intended as an exhaustive list of all issues that might arise.

Bureau Response: We will continue to review compatibility issues as they arise, and appreciate the feedback that MeAHP and others have provided to date. As with risk adjustment, these issues are best addressed in any implementation plan and waiver application if and when a preliminary decision has been made to proceed with implementation. Regarding the specific points raised, rescission of guaranteed-issue coverage is rarely justified, and we do not believe the differences in the language of the controlling standards for individual and group coverage are likely to be material. For grace periods, however, the differences between individual and small group coverage are significant. The issue is not the special three-month ACA grace period for advance premium tax credit (APTC) recipients; that is a feature of the APTC program rather than individual coverage in general. There are more fundamental differences under state law, between Maine's advance notice requirements for individual coverage under 24-A M.R.S. § 2707, and for group coverage under 24-A M.R.S. §§ 2809-A(1-A) & 4209(6). Maine always requires advance notice to enrollees before the carrier may cancel their coverage, but both the notice period (31 days for individual coverage as compared to 10 days for group coverage) and the structure of the notice process are different. Some of the differences are inherent in the difference between the individual and group coverage frameworks. Others reflect policy decisions made by the Legislature, but those, too, took into consideration differences between how individual and group policies are bought and administered. Harmonizing these provisions is not essential to the effective implementation of a pooled market. This raises the more general issue that provisions that relate to plan administration can never be identical for individual and group coverage, and the rule needs to be revised to clarify that the individual and group versions of a group health plan are permitted to vary in ways that are reasonably related to the differences in the mode of coverage, and do not affect the plan benefits or premium rates. The logical place for such a provision is in Subsection 5(1), and it has been added to that subsection, as explained earlier, as a new Paragraph 5(1)(E).

Section 6, MGARA reinsurance coverage

Comment: MGARA proposed revising Section 6 to accommodate non-calendar-year small group plans by adding a provision for "reimbursing eligible claims incurred during the calendar year that satisfy the applicable reinsurance thresholds regardless of the renewal date of the underlying policy." They acknowledge that it "would result in some claims that might otherwise have been eligible for reinsurance failing to qualify, and vice versa," but assert that it will balance out and yield a fair outcome consistent with the statutory intent and the purposes of MGARA, and has already been endorsed by MGARA's Board of Directors.

Bureau Response: MGARA framed this proposal as a mechanism that would facilitate revisions to the rule to restore carriers' ability to offer non-calendar-year plans to small employers. The permissibility of off-cycle plan years was never in question. However, that makes it all the more important to ensure that MGARA can effectively reconcile its calendar-year reinsurance program with a pooled market that includes small group policies written on a non-calendar-year basis. MGARA's proposal is consistent with 24-A M.R.S. § 3958(1)(A-1), which directs MGARA to cover "small group health plans issued in this State in [each] plan year" in which a pooled market is operating, while further specifying that reimbursement shall be "based on the total eligible claims paid during a calendar year for a single individual in excess of the attachment point specified by the board." *(Emphasis added)* The effect, as MGARA alluded in its comments, could be that claims incurred for a particular participant in one plan year fall entirely within the carrier's retention, while claims incurred in the next plan year are fully reinsured from the effective date of coverage through the end of the calendar year, after which a new retention begins to accumulate. However, as MGARA noted, each carrier's book of business is large enough that the gains and losses should offset each other in the aggregate, even when the employer changes carriers between plan years. Accordingly, we have revised Subsection 6(2) to add calendar-year attachment point accumulation to the list of issues that MGARA is directed to consider when updating its Plan Of Operation to address the implementation of the pooled market. The revisions to Section 6 also include two technical changes: a reference to reinsurance caps that was spotted when responding to Anthem's comment about ceding premiums, and the correction of a punctuation error at the very end of the section. As revised, Subsection 6(2) now reads as follows:

> *Amendments to Plan of Operation.* Within 45 days after the Superintendent issues a final decision to implement the pooled market, the Association shall file with the Superintendent all amendments to its Plan of Operation that the Association's board determines to be necessary, including, without limitation:
>
> A. The number of layers of coverage, ~~and~~ the attachment point and coinsurance percentage for each layer, and the cap, if any, for the top layer of coverage;
>
> B. The ceding premium, if any, to be charged;
>
> C. The accumulation of claims for participants enrolled in non-calendar-year small group plans; and
>
> ~~C.~~ D. Any other material terms of coverage.